

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10142

10150

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEWIS Middle HAMILTON Last ALEXANDER		4. DATE OF DEATH Month September Day 14 , Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 14 Days 15 Hours 58 Min.	IF UNDER 24 HRS. Hours 14 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Court Bailiff		10b. KIND OF BUSINESS OR INDUSTRY County	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin E. Alexander		14. MOTHER'S MAIDEN NAME Mary Catherine Stockman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-10-9629	
17. INFORMANT Mrs. Sylvia A. Alexander-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart dis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs + DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A-S Parkinsonism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 57 to 14 Sept 58 , that I last saw the deceased alive on 14 Sept 58 , and that death occurred at 5:30 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Professional Building,	
ACTUAL SIGNATURE Charles H. Conley, Jr.		DATE SIGNED 9/15/58	
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 17, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	22d. LOCATION (City, town, or county) (State) Woodsboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland	
24a. BY REGISTRAR SEP 16 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

<p>NAME OF DECEASED [REDACTED]</p>		<p>DATE OF DEATH [REDACTED]</p>	
<p>RESIDENCE [REDACTED]</p>		<p>PLACE OF DEATH [REDACTED]</p>	
<p>AGE [REDACTED]</p>		<p>SEX [REDACTED]</p>	
<p>EDUCATION [REDACTED]</p>		<p>OCCUPATION [REDACTED]</p>	
<p>CAUSE OF DEATH [REDACTED]</p>		<p>IMMEDIATE CAUSE [REDACTED]</p>	
<p>INTERVIEWED BY [REDACTED]</p>		<p>DATE OF INTERVIEW [REDACTED]</p>	
<p>SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>SIGNATURE OF DEATH REGISTRAR [REDACTED]</p>	
<p>DATE OF SIGNATURE [REDACTED]</p>		<p>DATE OF SIGNATURE [REDACTED]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10143

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Mt. Airy	
c. LENGTH OF STAY IN 1b 1 day		d. STREET ADDRESS R.F.D. 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First THOMAS Middle E. Last ANDERSON		4. DATE OF DEATH Month SEPT. Day 26 Year 1958	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1943
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY in school	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Stanley Anderson		14. MOTHER'S MAIDEN NAME Zelmor L. Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Zelmor Anderson, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 929.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in farm pond		20c. TIME OF INJURY Month, Day, Year 9 26 19 58 Hour 9 a.m. 3 p.m.	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) farm	
20f. (City or town) New Market, Frederick, Md.		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. C. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. C. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-26-1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-29-1958	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Odie Middle M. Last Baker				4. DATE OF DEATH Month 9 Day 29 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1886		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Keller				14. MOTHER'S MAIDEN NAME Emma Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Vernon S. Baker, Doubs, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis & hypertension DUE TO (c) 420.1						INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 2 yrs. 4+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 57 to 9/29 , 19 58 , that I last saw the deceased alive on 9/29 , 19 58 , and that death occurred at 9:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Conley, Jr.				ADDRESS (Street, city or town, state) Professional Bldg			
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.				DATE SIGNED 9/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/1/1958		22c. NAME OF CEMETERY OR CREMATORY Ch. of Brethren Cem.		22d. LOCATION (City, town, or county) (State) Harmony, Frederick Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company				ADDRESS , Middletown, Md.		24a. REC'D BY REGISTRAR DATE OCT 2 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH BALTIMORE, MD	
NAME OF DECEASED [Faint text]	SEX [Faint text]
AGE [Faint text]	DATE OF BIRTH [Faint text]
PLACE OF BIRTH [Faint text]	PLACE OF DEATH [Faint text]
OCCUPATION [Faint text]	CAUSE OF DEATH [Faint text]
DATE OF DEATH [Faint text]	TIME OF DEATH [Faint text]
SIGNATURE OF PHYSICIAN [Faint text]	SIGNATURE OF REGISTRAR [Faint text]
SIGNATURE OF WITNESS [Faint text]	SIGNATURE OF WITNESS [Faint text]



This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, MD. The Registrar will issue a certificate of death to the family of the deceased. The certificate of death is a legal document and must be kept for a period of ten years.

10175

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 East "A"				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Jane Barger				4. DATE OF DEATH Month 9 Day 16 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1898	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Henry Rothenhoefer				14. MOTHER'S MAIDEN NAME Martha Ellen Harshman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 000-00-0000		17. INFORMANT Mrs. Ellen Sponseller, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to (c) Due to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 6 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-9-58 to 9-16-58 , that I last saw the deceased alive on 9-16-58 , and that death occurred at 2:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE C.E. Pruitt				DATE SIGNED 9-16-58			
PHYSICIAN'S NAME (Type) C.E. Pruitt				ADDRESS Brunswick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-18-58		22c. NAME OF CEMETERY OR CREMATORY St. Marks		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Foster				ADDRESS Brunswick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the registrar. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		35		Jan 1, 1900		Maryland		Baltimore		Heart Disease		Jan 15, 1935		10:00 AM		Home		J. Doe, M.D.		J. Doe, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jane Smith		Female		45		Mar 10, 1890		Maryland		Baltimore		Cancer		Mar 20, 1935		2:00 PM		Hospital		J. Smith, M.D.		J. Smith, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Robert Johnson		Male		25		Jul 5, 1910		Maryland		Baltimore		Accident		Apr 10, 1935		5:00 PM		Street		J. Johnson, M.D.		J. Johnson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Mary White		Female		60		Sep 1, 1875		Maryland		Baltimore		Stroke		May 5, 1935		11:00 AM		Home		J. White, M.D.		J. White, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Charles Brown		Male		50		Nov 15, 1885		Maryland		Baltimore		Pneumonia		Jun 1, 1935		3:00 PM		Hospital		J. Brown, M.D.		J. Brown, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Elizabeth Green		Female		30		Dec 1, 1905		Maryland		Baltimore		Tuberculosis		Jul 10, 1935		8:00 AM		Hospital		J. Green, M.D.		J. Green, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
William Black		Male		40		Aug 20, 1895		Maryland		Baltimore		Heart Disease		Aug 25, 1935		1:00 PM		Home		J. Black, M.D.		J. Black, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Margaret Hall		Female		55		Apr 10, 1880		Maryland		Baltimore		Cancer		Sep 15, 1935		4:00 PM		Hospital		J. Hall, M.D.		J. Hall, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Thomas King		Male		38		Jun 5, 1897		Maryland		Baltimore		Accident		Oct 1, 1935		6:00 PM		Street		J. King, M.D.		J. King, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Anna Lee		Female		65		Mar 1, 1870		Maryland		Baltimore		Stroke		Oct 10, 1935		9:00 AM		Home		J. Lee, M.D.		J. Lee, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
George Miller		Male		42		Feb 15, 1893		Maryland		Baltimore		Pneumonia		Nov 5, 1935		12:00 PM		Hospital		J. Miller, M.D.		J. Miller, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Helen Wilson		Female		33		Oct 1, 1902		Maryland		Baltimore		Tuberculosis		Nov 15, 1935		7:00 AM		Hospital		J. Wilson, M.D.		J. Wilson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frank Davis		Male		58		May 10, 1877		Maryland		Baltimore		Heart Disease		Dec 1, 1935		10:00 AM		Home		J. Davis, M.D.		J. Davis, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Grace Evans		Female		48		Jan 20, 1887		Maryland		Baltimore		Cancer		Dec 15, 1935		3:00 PM		Hospital		J. Evans, M.D.		J. Evans, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Albert Foster		Male		35		Sep 5, 1900		Maryland		Baltimore		Accident		Dec 20, 1935		11:00 PM		Street		J. Foster, M.D.		J. Foster, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Betty Green		Female		28		Jul 10, 1907		Maryland		Baltimore		Tuberculosis		Jan 5, 1936		8:00 AM		Hospital		J. Green, M.D.		J. Green, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Harold King		Male		45		Apr 1, 1891		Maryland		Baltimore		Heart Disease		Jan 10, 1936		2:00 PM		Home		J. King, M.D.		J. King, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lillian Lee		Female		52		Mar 15, 1884		Maryland		Baltimore		Cancer		Jan 20, 1936		9:00 AM		Hospital		J. Lee, M.D.		J. Lee, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Clarence Miller		Male		30		Nov 1, 1906		Maryland		Baltimore		Accident		Jan 25, 1936		4:00 PM		Street		J. Miller, M.D.		J. Miller, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Dorothy Wilson		Female		25		Aug 10, 1911		Maryland		Baltimore		Tuberculosis		Feb 5, 1936		7:00 AM		Hospital		J. Wilson, M.D.		J. Wilson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Eugene Davis		Male		40		Jun 1, 1896		Maryland		Baltimore		Heart Disease		Feb 10, 1936		1:00 PM		Home		J. Davis, M.D.		J. Davis, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Florence Evans		Female		50		May 1, 1886		Maryland		Baltimore		Cancer		Feb 15, 1936		3:00 PM		Hospital		J. Evans, M.D.		J. Evans, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Walter Foster		Male		35		Sep 1, 1901		Maryland		Baltimore		Accident		Feb 20, 1936		11:00 PM		Street		J. Foster, M.D.		J. Foster, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Gladys Green		Female		28		Oct 1, 1908		Maryland		Baltimore		Tuberculosis		Mar 5, 1936		8:00 AM		Hospital		J. Green, M.D.		J. Green, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Herbert King		Male		42		Jul 1, 1894		Maryland		Baltimore		Heart Disease		Mar 10, 1936		2:00 PM		Home		J. King, M.D.		J. King, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Irene Lee		Female		55		Apr 1, 1881		Maryland		Baltimore		Cancer		Mar 15, 1936		9:00 AM		Hospital		J. Lee, M.D.		J. Lee, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Kenneth Miller		Male		30		Nov 1, 1906		Maryland		Baltimore		Accident		Mar 20, 1936		4:00 PM		Street		J. Miller, M.D.		J. Miller, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Lillian Wilson		Female		25		Aug 1, 1911		Maryland		Baltimore		Tuberculosis		Apr 5, 1936		7:00 AM		Hospital		J. Wilson, M.D.		J. Wilson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Maurice Davis		Male		40		Jun 1, 1896		Maryland		Baltimore		Heart Disease		Apr 10, 1936		1:00 PM		Home		J. Davis, M.D.		J. Davis, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Nancy Evans		Female		50		May 1, 1886		Maryland		Baltimore		Cancer		Apr 15, 1936		3:00 PM		Hospital		J. Evans, M.D.		J. Evans, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Oscar Foster		Male		35		Sep 1, 1901		Maryland		Baltimore		Accident		Apr 20, 1936		11:00 PM		Street		J. Foster, M.D.		J. Foster, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Paula Green		Female		28		Oct 1, 1908		Maryland		Baltimore		Tuberculosis		May 5, 1936		8:00 AM		Hospital		J. Green, M.D.		J. Green, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Ralph King		Male		42		Jul 1, 1894		Maryland		Baltimore		Heart Disease		May 10, 1936		2:00 PM		Home		J. King, M.D.		J. King, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Sara Lee		Female		55		Apr 1, 1881		Maryland		Baltimore		Cancer		May 15, 1936		9:00 AM		Hospital		J. Lee, M.D.		J. Lee, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Timothy Miller		Male		30		Nov 1, 1906		Maryland		Baltimore		Accident		May 20, 1936		4:00 PM		Street		J. Miller, M.D.		J. Miller, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Verna Wilson		Female		25		Aug 1, 1911		Maryland		Baltimore		Tuberculosis		Jun 5, 1936		7:00 AM		Hospital		J. Wilson, M.D.		J. Wilson, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Walter Davis		Male		40		Jun 1, 1896		Maryland		Baltimore		Heart Disease		Jun 10, 1936		1:00 PM		Home		J. Davis, M.D.		J. Davis, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Xenia Evans		Female		50		May 1, 1886		Maryland		Baltimore		Cancer		Jun 15, 1936		3:00 PM		Hospital		J. Evans, M.D.		J. Evans, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Yvonne Foster		Female		35		Sep 1, 1901		Maryland		Baltimore		Accident		Jun 20, 1936		11:00 PM		Street		J. Foster, M.D.		J. Foster, Registrar	
Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10152

CERTIFICATE OF DEATH

10146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Mem. Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>ELSIE G. Boone</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-1-1872</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Daniel P. Zimmerman</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Stitely</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>MRS. C. W. Miller-Woodboro-Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x Broncho-pneumonia</i> DUE TO (b) <i>Arterio-sclerotic C.V.D.</i> DUE TO (c) <i>Diabetes Mellitus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>10 years</i> <i>7 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>491x</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec. 1, 1945</i> , to <i>Sept. 19, 1958</i> , that I last saw the deceased alive on <i>Sept. 19, 1958</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard O. Thomas Jr.</i> M.D.		ADDRESS (Street, city or town, state) <i>228 N. Market St. Frederick, Md.</i> DATE SIGNED <i>9/19/58</i>	
PHYSICIAN'S NAME (Type) <i>DR. BERNARD O. THOMAS-JR.</i>		<i>Frederick, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>9-21-1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. HOPE CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WOODSBORO-MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Cline & Son</i>		ADDRESS <i>FREDERICK-MD.</i>	
24a. REC'D BY REGISTRAR <i>SEP 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

10179

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceham			
				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lemuel First Bowers Middle Bowers Last				4. DATE OF DEATH Month Sept. Day 6 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Bowers				14. MOTHER'S MAIDEN NAME Elizabeth Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-36-2981		17. INFORMANT Mrs. Warren Grushon		Address Graceham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial ischemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Direct inguinal hernia, right							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Thurmont, Maryland		(County) (State)	
21. I certify that I attended the deceased from July 31, 1958 to Sept. 6, 1958 , that I last saw the deceased alive on Sept. 6, 1958 and that death occurred at 5:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Franklin Birely		M.D. Thurmont, Md.		ADDRESS (Street, city or town, state) Thurmont, Md.		DATE SIGNED Sept 10 58	
PHYSICIAN'S NAME (Type) M. FRANKLIN BIRELY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-9-58	22c. NAME OF CEMETERY OR CREMATORY United Brethern Cem.		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24c. REGISTRAR'S SIGNATURE Arthur L. Kneel	
				24b. REC'D BY REGISTRAR SEP 10 58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WILSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10180
CERTIFICATE OF DEATH

10148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights			c. LENGTH OF STAY IN It Since 4/58			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home				d. STREET ADDRESS Near Mount Pleasant			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle ELIZABETH Last BUCKEY				4. DATE OF DEATH Month September Day 18 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Sept 1883		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hamilton Etzler				14. MOTHER'S MAIDEN NAME Susan Munshower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address W. Maynard Buckey: (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic feline bones DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 3 months 3 months							INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 50 , to Sept. 18 , 19 58 , that I last saw the deceased alive on Sept. 18 , 19 58 , and that death occurred at 3:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 9-19-58							
ACTUAL SIGNATURE B. O. Thomas M.D.				PHYSICIAN'S NAME (Type) B. O. Thomas, M. D. Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-58		22c. NAME OF CEMETERY OR CREMATORY Glade Cemetery		22d. LOCATION (City, town, or county) (State) Walkersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR SEP 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1918

1918

NAME OF DECEASED [Name]		SEX [Sex]		AGE [Age]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]	
DATE OF DEATH [Date]		TIME OF DEATH [Time]		PLACE OF DEATH [Place]	
NAME OF PHYSICIAN [Physician]		NAME OF FUNERAL HOME [Funeral Home]		NAME OF BURIAL PLACE [Burial Place]	
NAME OF NEXT OF KIN [Next of Kin]		NAME OF MINISTER [Minister]		NAME OF CLERGYMAN [Clergyman]	
NAME OF CORONER [Coroner]		NAME OF JURY [Jury]		NAME OF JUDGE [Judge]	
NAME OF SHERIFF [Sheriff]		NAME OF CLERK [Clerk]		NAME OF RECORDS [Records]	
NAME OF DECEASED'S MOTHER [Mother]		NAME OF DECEASED'S FATHER [Father]		NAME OF DECEASED'S SPOUSE [Spouse]	
NAME OF DECEASED'S CHILDREN [Children]		NAME OF DECEASED'S BROTHERS [Brothers]		NAME OF DECEASED'S SISTERS [Sisters]	
NAME OF DECEASED'S GRANDPARENTS [Grandparents]		NAME OF DECEASED'S UNCLE [Uncle]		NAME OF DECEASED'S AUNT [Aunt]	
NAME OF DECEASED'S NEPHEW [Nephew]		NAME OF DECEASED'S NIECE [Niece]		NAME OF DECEASED'S COUSIN [Cousin]	
NAME OF DECEASED'S FIRST COUNSELOR [First Counselor]		NAME OF DECEASED'S SECOND COUNSELOR [Second Counselor]		NAME OF DECEASED'S THIRD COUNSELOR [Third Counselor]	
NAME OF DECEASED'S FOURTH COUNSELOR [Fourth Counselor]		NAME OF DECEASED'S FIFTH COUNSELOR [Fifth Counselor]		NAME OF DECEASED'S SIXTH COUNSELOR [Sixth Counselor]	
NAME OF DECEASED'S SEVENTH COUNSELOR [Seventh Counselor]		NAME OF DECEASED'S EIGHTH COUNSELOR [Eighth Counselor]		NAME OF DECEASED'S NINTH COUNSELOR [Ninth Counselor]	
NAME OF DECEASED'S TENTH COUNSELOR [Tenth Counselor]		NAME OF DECEASED'S ELEVENTH COUNSELOR [Eleventh Counselor]		NAME OF DECEASED'S TWELFTH COUNSELOR [Twelfth Counselor]	
NAME OF DECEASED'S THIRTEENTH COUNSELOR [Thirteenth Counselor]		NAME OF DECEASED'S FOURTEENTH COUNSELOR [Fourteenth Counselor]		NAME OF DECEASED'S FIFTEENTH COUNSELOR [Fifteenth Counselor]	
NAME OF DECEASED'S SIXTEENTH COUNSELOR [Sixteenth Counselor]		NAME OF DECEASED'S SEVENTEENTH COUNSELOR [Seventeenth Counselor]		NAME OF DECEASED'S EIGHTEENTH COUNSELOR [Eighteenth Counselor]	
NAME OF DECEASED'S NINETEENTH COUNSELOR [Nineteenth Counselor]		NAME OF DECEASED'S TWENTIETH COUNSELOR [Twentieth Counselor]		NAME OF DECEASED'S TWENTY-FIRST COUNSELOR [Twenty-First Counselor]	
NAME OF DECEASED'S TWENTY-SECOND COUNSELOR [Twenty-Second Counselor]		NAME OF DECEASED'S TWENTY-THIRD COUNSELOR [Twenty-Third Counselor]		NAME OF DECEASED'S TWENTY-FOURTH COUNSELOR [Twenty-Fourth Counselor]	
NAME OF DECEASED'S TWENTY-FIFTH COUNSELOR [Twenty-Fifth Counselor]		NAME OF DECEASED'S TWENTY-SIXTH COUNSELOR [Twenty-Sixth Counselor]		NAME OF DECEASED'S TWENTY-SEVENTH COUNSELOR [Twenty-Seventh Counselor]	
NAME OF DECEASED'S TWENTY-EIGHTH COUNSELOR [Twenty-Eighth Counselor]		NAME OF DECEASED'S TWENTY-NINTH COUNSELOR [Twenty-Ninth Counselor]		NAME OF DECEASED'S THIRTIETH COUNSELOR [Thirtieth Counselor]	
NAME OF DECEASED'S THIRTY-FIRST COUNSELOR [Thirty-First Counselor]		NAME OF DECEASED'S THIRTY-SECOND COUNSELOR [Thirty-Second Counselor]		NAME OF DECEASED'S THIRTY-THIRD COUNSELOR [Thirty-Third Counselor]	
NAME OF DECEASED'S THIRTY-FOURTH COUNSELOR [Thirty-Fourth Counselor]		NAME OF DECEASED'S THIRTY-FIFTH COUNSELOR [Thirty-Fifth Counselor]		NAME OF DECEASED'S THIRTY-SIXTH COUNSELOR [Thirty-Sixth Counselor]	
NAME OF DECEASED'S THIRTY-SEVENTH COUNSELOR [Thirty-Seventh Counselor]		NAME OF DECEASED'S THIRTY-EIGHTH COUNSELOR [Thirty-Eighth Counselor]		NAME OF DECEASED'S THIRTY-NINTH COUNSELOR [Thirty-Ninth Counselor]	
NAME OF DECEASED'S FORTY COUNSELOR [Forty Counselor]		NAME OF DECEASED'S FORTY-FIRST COUNSELOR [Forty-First Counselor]		NAME OF DECEASED'S FORTY-SECOND COUNSELOR [Forty-Second Counselor]	
NAME OF DECEASED'S FORTY-THIRD COUNSELOR [Forty-Third Counselor]		NAME OF DECEASED'S FORTY-FOURTH COUNSELOR [Forty-Fourth Counselor]		NAME OF DECEASED'S FORTY-FIFTH COUNSELOR [Forty-Fifth Counselor]	
NAME OF DECEASED'S FORTY-SIXTH COUNSELOR [Forty-Sixth Counselor]		NAME OF DECEASED'S FORTY-SEVENTH COUNSELOR [Forty-Seventh Counselor]		NAME OF DECEASED'S FORTY-EIGHTH COUNSELOR [Forty-Eighth Counselor]	
NAME OF DECEASED'S FORTY-NINTH COUNSELOR [Forty-Ninth Counselor]		NAME OF DECEASED'S FIFTY COUNSELOR [Fifty Counselor]		NAME OF DECEASED'S FIFTY-FIRST COUNSELOR [Fifty-First Counselor]	
NAME OF DECEASED'S FIFTY-SECOND COUNSELOR [Fifty-Second Counselor]		NAME OF DECEASED'S FIFTY-THIRD COUNSELOR [Fifty-Third Counselor]		NAME OF DECEASED'S FIFTY-FOURTH COUNSELOR [Fifty-Fourth Counselor]	
NAME OF DECEASED'S FIFTY-FIFTH COUNSELOR [Fifty-Fifth Counselor]		NAME OF DECEASED'S FIFTY-SIXTH COUNSELOR [Fifty-Sixth Counselor]		NAME OF DECEASED'S FIFTY-SEVENTH COUNSELOR [Fifty-Seventh Counselor]	
NAME OF DECEASED'S FIFTY-EIGHTH COUNSELOR [Fifty-Eighth Counselor]		NAME OF DECEASED'S FIFTY-NINTH COUNSELOR [Fifty-Ninth Counselor]		NAME OF DECEASED'S SIXTY COUNSELOR [Sixty Counselor]	
NAME OF DECEASED'S SIXTY-FIRST COUNSELOR [Sixty-First Counselor]		NAME OF DECEASED'S SIXTY-SECOND COUNSELOR [Sixty-Second Counselor]		NAME OF DECEASED'S SIXTY-THIRD COUNSELOR [Sixty-Third Counselor]	
NAME OF DECEASED'S SIXTY-FOURTH COUNSELOR [Sixty-Fourth Counselor]		NAME OF DECEASED'S SIXTY-FIFTH COUNSELOR [Sixty-Fifth Counselor]		NAME OF DECEASED'S SIXTY-SIXTH COUNSELOR [Sixty-Sixth Counselor]	
NAME OF DECEASED'S SIXTY-SEVENTH COUNSELOR [Sixty-Seventh Counselor]		NAME OF DECEASED'S SIXTY-EIGHTH COUNSELOR [Sixty-Eighth Counselor]		NAME OF DECEASED'S SIXTY-NINTH COUNSELOR [Sixty-Ninth Counselor]	
NAME OF DECEASED'S SEVENTY COUNSELOR [Seventy Counselor]		NAME OF DECEASED'S SEVENTY-FIRST COUNSELOR [Seventy-First Counselor]		NAME OF DECEASED'S SEVENTY-SECOND COUNSELOR [Seventy-Second Counselor]	
NAME OF DECEASED'S SEVENTY-THIRD COUNSELOR [Seventy-Third Counselor]		NAME OF DECEASED'S SEVENTY-FOURTH COUNSELOR [Seventy-Fourth Counselor]		NAME OF DECEASED'S SEVENTY-FIFTH COUNSELOR [Seventy-Fifth Counselor]	
NAME OF DECEASED'S SEVENTY-SIXTH COUNSELOR [Seventy-Sixth Counselor]		NAME OF DECEASED'S SEVENTY-SEVENTH COUNSELOR [Seventy-Seventh Counselor]		NAME OF DECEASED'S SEVENTY-EIGHTH COUNSELOR [Seventy-Eighth Counselor]	
NAME OF DECEASED'S SEVENTY-NINTH COUNSELOR [Seventy-Ninth Counselor]		NAME OF DECEASED'S EIGHTY COUNSELOR [Eighty Counselor]		NAME OF DECEASED'S EIGHTY-FIRST COUNSELOR [Eighty-First Counselor]	
NAME OF DECEASED'S EIGHTY-SECOND COUNSELOR [Eighty-Second Counselor]		NAME OF DECEASED'S EIGHTY-THIRD COUNSELOR [Eighty-Third Counselor]		NAME OF DECEASED'S EIGHTY-FOURTH COUNSELOR [Eighty-Fourth Counselor]	
NAME OF DECEASED'S EIGHTY-FIFTH COUNSELOR [Eighty-Fifth Counselor]		NAME OF DECEASED'S EIGHTY-SIXTH COUNSELOR [Eighty-Sixth Counselor]		NAME OF DECEASED'S EIGHTY-SEVENTH COUNSELOR [Eighty-Seventh Counselor]	
NAME OF DECEASED'S EIGHTY-EIGHTH COUNSELOR [Eighty-Eighth Counselor]		NAME OF DECEASED'S EIGHTY-NINTH COUNSELOR [Eighty-Ninth Counselor]		NAME OF DECEASED'S NINETY COUNSELOR [Ninety Counselor]	
NAME OF DECEASED'S NINETY-FIRST COUNSELOR [Ninety-First Counselor]		NAME OF DECEASED'S NINETY-SECOND COUNSELOR [Ninety-Second Counselor]		NAME OF DECEASED'S NINETY-THIRD COUNSELOR [Ninety-Third Counselor]	
NAME OF DECEASED'S NINETY-FOURTH COUNSELOR [Ninety-Fourth Counselor]		NAME OF DECEASED'S NINETY-FIFTH COUNSELOR [Ninety-Fifth Counselor]		NAME OF DECEASED'S NINETY-SIXTH COUNSELOR [Ninety-Sixth Counselor]	
NAME OF DECEASED'S NINETY-SEVENTH COUNSELOR [Ninety-Seventh Counselor]		NAME OF DECEASED'S NINETY-EIGHTH COUNSELOR [Ninety-Eighth Counselor]		NAME OF DECEASED'S NINETY-NINTH COUNSELOR [Ninety-Ninth Counselor]	
NAME OF DECEASED'S HUNDRED COUNSELOR [Hundred Counselor]		NAME OF DECEASED'S HUNDRED-FIRST COUNSELOR [Hundred-First Counselor]		NAME OF DECEASED'S HUNDRED-SECOND COUNSELOR [Hundred-Second Counselor]	
NAME OF DECEASED'S HUNDRED-THIRD COUNSELOR [Hundred-Third Counselor]		NAME OF DECEASED'S HUNDRED-FOURTH COUNSELOR [Hundred-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-FIFTH COUNSELOR [Hundred-Fifth Counselor]	
NAME OF DECEASED'S HUNDRED-SIXTH COUNSELOR [Hundred-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTH COUNSELOR [Hundred-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTH COUNSELOR [Hundred-Eighth Counselor]	
NAME OF DECEASED'S HUNDRED-NINTH COUNSELOR [Hundred-Ninth Counselor]		NAME OF DECEASED'S HUNDRED-TENTH COUNSELOR [Hundred-Tenth Counselor]		NAME OF DECEASED'S HUNDRED-ELEVENTH COUNSELOR [Hundred-Eleventh Counselor]	
NAME OF DECEASED'S HUNDRED-TWELFTH COUNSELOR [Hundred-Twelfth Counselor]		NAME OF DECEASED'S HUNDRED-THIRTEENTH COUNSELOR [Hundred-Thirteenth Counselor]		NAME OF DECEASED'S HUNDRED-FOURTEENTH COUNSELOR [Hundred-Fourteenth Counselor]	
NAME OF DECEASED'S HUNDRED-FIFTEENTH COUNSELOR [Hundred-Fifteenth Counselor]		NAME OF DECEASED'S HUNDRED-SIXTEENTH COUNSELOR [Hundred-Sixteenth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTEENTH COUNSELOR [Hundred-Seventeenth Counselor]	
NAME OF DECEASED'S HUNDRED-EIGHTEENTH COUNSELOR [Hundred-Eighteenth Counselor]		NAME OF DECEASED'S HUNDRED-NINETEENTH COUNSELOR [Hundred-Nineteenth Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY COUNSELOR [Hundred-Twentieth Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-FIRST COUNSELOR [Hundred-Twenty-First Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-SECOND COUNSELOR [Hundred-Twenty-Second Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-THIRD COUNSELOR [Hundred-Twenty-Third Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-FOURTH COUNSELOR [Hundred-Twenty-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-FIFTH COUNSELOR [Hundred-Twenty-Fifth Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-SIXTH COUNSELOR [Hundred-Twenty-Sixth Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-SEVENTH COUNSELOR [Hundred-Twenty-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-EIGHTH COUNSELOR [Hundred-Twenty-Eighth Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-NINTH COUNSELOR [Hundred-Twenty-Ninth Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY COUNSELOR [Hundred-Thirtieth Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-FIRST COUNSELOR [Hundred-Thirty-First Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-SECOND COUNSELOR [Hundred-Thirty-Second Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-THIRD COUNSELOR [Hundred-Thirty-Third Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-FOURTH COUNSELOR [Hundred-Thirty-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-FIFTH COUNSELOR [Hundred-Thirty-Fifth Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-SIXTH COUNSELOR [Hundred-Thirty-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-SEVENTH COUNSELOR [Hundred-Thirty-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-EIGHTH COUNSELOR [Hundred-Thirty-Eighth Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-NINTH COUNSELOR [Hundred-Thirty-Ninth Counselor]		NAME OF DECEASED'S HUNDRED-FORTY COUNSELOR [Hundred-Fortieth Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-FIRST COUNSELOR [Hundred-Forty-First Counselor]	
NAME OF DECEASED'S HUNDRED-FORTY-SECOND COUNSELOR [Hundred-Forty-Second Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-THIRD COUNSELOR [Hundred-Forty-Third Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-FOURTH COUNSELOR [Hundred-Forty-Fourth Counselor]	
NAME OF DECEASED'S HUNDRED-FORTY-FIFTH COUNSELOR [Hundred-Forty-Fifth Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-SIXTH COUNSELOR [Hundred-Forty-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-SEVENTH COUNSELOR [Hundred-Forty-Seventh Counselor]	
NAME OF DECEASED'S HUNDRED-FORTY-EIGHTH COUNSELOR [Hundred-Forty-Eighth Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-NINTH COUNSELOR [Hundred-Forty-Ninth Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY COUNSELOR [Hundred-Fiftieth Counselor]	
NAME OF DECEASED'S HUNDRED-FIFTY-FIRST COUNSELOR [Hundred-Fifty-First Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-SECOND COUNSELOR [Hundred-Fifty-Second Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-THIRD COUNSELOR [Hundred-Fifty-Third Counselor]	
NAME OF DECEASED'S HUNDRED-FIFTY-FOURTH COUNSELOR [Hundred-Fifty-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-FIFTH COUNSELOR [Hundred-Fifty-Fifth Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-SIXTH COUNSELOR [Hundred-Fifty-Sixth Counselor]	
NAME OF DECEASED'S HUNDRED-FIFTY-SEVENTH COUNSELOR [Hundred-Fifty-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-EIGHTH COUNSELOR [Hundred-Fifty-Eighth Counselor]		NAME OF DECEASED'S HUNDRED-FIFTY-NINTH COUNSELOR [Hundred-Fifty-Ninth Counselor]	
NAME OF DECEASED'S HUNDRED-SIXTY COUNSELOR [Hundred-Sixtieth Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-FIRST COUNSELOR [Hundred-Sixty-First Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-SECOND COUNSELOR [Hundred-Sixty-Second Counselor]	
NAME OF DECEASED'S HUNDRED-SIXTY-THIRD COUNSELOR [Hundred-Sixty-Third Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-FOURTH COUNSELOR [Hundred-Sixty-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-FIFTH COUNSELOR [Hundred-Sixty-Fifth Counselor]	
NAME OF DECEASED'S HUNDRED-SIXTY-SIXTH COUNSELOR [Hundred-Sixty-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-SEVENTH COUNSELOR [Hundred-Sixty-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-SIXTY-EIGHTH COUNSELOR [Hundred-Sixty-Eighth Counselor]	
NAME OF DECEASED'S HUNDRED-SIXTY-NINTH COUNSELOR [Hundred-Sixty-Ninth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTY COUNSELOR [Hundred-Seventieth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTY-FIRST COUNSELOR [Hundred-Seventy-First Counselor]	
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NAME OF DECEASED'S HUNDRED-SEVENTY-FIFTH COUNSELOR [Hundred-Seventy-Fifth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTY-SIXTH COUNSELOR [Hundred-Seventy-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTY-SEVENTH COUNSELOR [Hundred-Seventy-Seventh Counselor]	
NAME OF DECEASED'S HUNDRED-SEVENTY-EIGHTH COUNSELOR [Hundred-Seventy-Eighth Counselor]		NAME OF DECEASED'S HUNDRED-SEVENTY-NINTH COUNSELOR [Hundred-Seventy-Ninth Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY COUNSELOR [Hundred-Eightieth Counselor]	
NAME OF DECEASED'S HUNDRED-EIGHTY-FIRST COUNSELOR [Hundred-Eighty-First Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-SECOND COUNSELOR [Hundred-Eighty-Second Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-THIRD COUNSELOR [Hundred-Eighty-Third Counselor]	
NAME OF DECEASED'S HUNDRED-EIGHTY-FOURTH COUNSELOR [Hundred-Eighty-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-FIFTH COUNSELOR [Hundred-Eighty-Fifth Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-SIXTH COUNSELOR [Hundred-Eighty-Sixth Counselor]	
NAME OF DECEASED'S HUNDRED-EIGHTY-SEVENTH COUNSELOR [Hundred-Eighty-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-EIGHTH COUNSELOR [Hundred-Eighty-Eighth Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTY-NINTH COUNSELOR [Hundred-Eighty-Ninth Counselor]	
NAME OF DECEASED'S HUNDRED-NINETY COUNSELOR [Hundred-Ninetieth Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-FIRST COUNSELOR [Hundred-Ninety-First Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-SECOND COUNSELOR [Hundred-Ninety-Second Counselor]	
NAME OF DECEASED'S HUNDRED-NINETY-THIRD COUNSELOR [Hundred-Ninety-Third Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-FOURTH COUNSELOR [Hundred-Ninety-Fourth Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-FIFTH COUNSELOR [Hundred-Ninety-Fifth Counselor]	
NAME OF DECEASED'S HUNDRED-NINETY-SIXTH COUNSELOR [Hundred-Ninety-Sixth Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-SEVENTH COUNSELOR [Hundred-Ninety-Seventh Counselor]		NAME OF DECEASED'S HUNDRED-NINETY-EIGHTH COUNSELOR [Hundred-Ninety-Eighth Counselor]	
NAME OF DECEASED'S HUNDRED-NINETY-NINTH COUNSELOR [Hundred-Ninety-Ninth Counselor]		NAME OF DECEASED'S HUNDRED COUNSELOR [Hundred Counselor]		NAME OF DECEASED'S HUNDRED-ONE COUNSELOR [Hundred-One Counselor]	
NAME OF DECEASED'S HUNDRED-TWO COUNSELOR [Hundred-Two Counselor]		NAME OF DECEASED'S HUNDRED-THREE COUNSELOR [Hundred-Three Counselor]		NAME OF DECEASED'S HUNDRED-FOUR COUNSELOR [Hundred-Four Counselor]	
NAME OF DECEASED'S HUNDRED-FIVE COUNSELOR [Hundred-Five Counselor]		NAME OF DECEASED'S HUNDRED-SIX COUNSELOR [Hundred-Six Counselor]		NAME OF DECEASED'S HUNDRED-SEVEN COUNSELOR [Hundred-Seven Counselor]	
NAME OF DECEASED'S HUNDRED-EIGHT COUNSELOR [Hundred-Eight Counselor]		NAME OF DECEASED'S HUNDRED-NINE COUNSELOR [Hundred-Nine Counselor]		NAME OF DECEASED'S HUNDRED-TEN COUNSELOR [Hundred-Ten Counselor]	
NAME OF DECEASED'S HUNDRED-ELEVEN COUNSELOR [Hundred-Eleven Counselor]		NAME OF DECEASED'S HUNDRED-TWELVE COUNSELOR [Hundred-Twelve Counselor]		NAME OF DECEASED'S HUNDRED-THIRTEEN COUNSELOR [Hundred-Thirteen Counselor]	
NAME OF DECEASED'S HUNDRED-FOURTEEN COUNSELOR [Hundred-Fourteen Counselor]		NAME OF DECEASED'S HUNDRED-FIFTEEN COUNSELOR [Hundred-Fifteen Counselor]		NAME OF DECEASED'S HUNDRED-SIXTEEN COUNSELOR [Hundred-Sixteen Counselor]	
NAME OF DECEASED'S HUNDRED-SEVENTEEN COUNSELOR [Hundred-Seventeen Counselor]		NAME OF DECEASED'S HUNDRED-EIGHTEEN COUNSELOR [Hundred-Eighteen Counselor]		NAME OF DECEASED'S HUNDRED-NINETEEN COUNSELOR [Hundred-Nineteen Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY COUNSELOR [Hundred-Twenty Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-ONE COUNSELOR [Hundred-Twenty-One Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-TWO COUNSELOR [Hundred-Twenty-Two Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-THREE COUNSELOR [Hundred-Twenty-Three Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-FOUR COUNSELOR [Hundred-Twenty-Four Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-FIVE COUNSELOR [Hundred-Twenty-Five Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-SIX COUNSELOR [Hundred-Twenty-Six Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-SEVEN COUNSELOR [Hundred-Twenty-Seven Counselor]		NAME OF DECEASED'S HUNDRED-TWENTY-EIGHT COUNSELOR [Hundred-Twenty-Eight Counselor]	
NAME OF DECEASED'S HUNDRED-TWENTY-NINE COUNSELOR [Hundred-Twenty-Nine Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY COUNSELOR [Hundred-Thirty Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-ONE COUNSELOR [Hundred-Thirty-One Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-TWO COUNSELOR [Hundred-Thirty-Two Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-THREE COUNSELOR [Hundred-Thirty-Three Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-FOUR COUNSELOR [Hundred-Thirty-Four Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-FIVE COUNSELOR [Hundred-Thirty-Five Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-SIX COUNSELOR [Hundred-Thirty-Six Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-SEVEN COUNSELOR [Hundred-Thirty-Seven Counselor]	
NAME OF DECEASED'S HUNDRED-THIRTY-EIGHT COUNSELOR [Hundred-Thirty-Eight Counselor]		NAME OF DECEASED'S HUNDRED-THIRTY-NINE COUNSELOR [Hundred-Thirty-Nine Counselor]		NAME OF DECEASED'S HUNDRED-FORTY COUNSELOR [Hundred-Fortieth Counselor]	
NAME OF DECEASED'S HUNDRED-FORTY-ONE COUNSELOR [Hundred-Forty-One Counselor]		NAME OF DECEASED'S HUNDRED-FORTY-TWO COUNSELOR [Hundred-Forty-Two Counselor]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10149

10153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Fredrick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fredrick</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fredrick Memorial</i>				d. STREET ADDRESS <i>13X-2</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Jo</i> Middle <i>Ann</i> Last <i>Burdette</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>9</i> Year <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 9 1918</i>	9. AGE (In years last birthday) yrs. <i>1</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>--</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>--</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Emory Burdette</i>				14. MOTHER'S MAIDEN NAME <i>Dorothy Linton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>--</i>		16. SOCIAL SECURITY NO. <i>--</i>		17. INFORMANT <i>Father</i>		Address <i>Mt. Airy R.F.D. 3</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.5</i> DUE TO <i>Congenital Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Complete Transposition of the</i> (c) <i>Great Vessels</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Life</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7:45</i> , 19 <i>58</i> , to <i>9:45</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9-8-58</i> , 19 <i>58</i> , and that death occurred at <i>7:45</i> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>F. J. Helorich</i> M.D.				PHYSICIAN'S NAME (Type) <i>F. J. Helorich</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 11, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Pine Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Mt. Airy, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Chas. L. Moleworth</i>				ADDRESS <i>Damascus, Md.</i>		24a. REC'D BY REGISTRAR <i>SEP 15 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

1000426XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10154

CERTIFICATE OF DEATH

10150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u> <u>06x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				d. STREET ADDRESS <u>Route 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Condon</u> Last <u>Condon</u>			4. DATE OF DEATH Month <u>Sep.</u> Day <u>1</u> Year <u>1958</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/84</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W^M G. CONDON</u>				14. MOTHER'S MAIDEN NAME <u>Josephine LONG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Mrs. Marion Hipshy - Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of brain</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of cerebral artery</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 wks.</u> <u>10 years +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>58</u> , to <u>9/1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/1</u> , 19 <u>58</u> , and that death occurred at <u>11:55 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>9/2/58</u> ACTUAL SIGNATURE <u>Henry V Chase</u> M.D. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasa</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		JAN 15 1900		BALTIMORE		JAMES H. HARRIS		JAN 15 1900		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DATE		PLACE	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		JAN 15 1900		BALTIMORE	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
CLOCK REPAIRER		JAN 15 1900		BALTIMORE		JAMES H. HARRIS		JAN 15 1900		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HEART DISEASE		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
NATURAL		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
PLACE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
HOME		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
DATE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
JAN 15 1925		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
SIGNATURE OF DECEASED		DATE		PLACE		NAME		DATE		PLACE	
JAMES H. HARRIS		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
SIGNATURE OF WITNESSES		DATE		PLACE		NAME		DATE		PLACE	
JAMES H. HARRIS		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE	
JAMES H. HARRIS		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	
SIGNATURE OF CLERK		DATE		PLACE		NAME		DATE		PLACE	
JAMES H. HARRIS		JAN 15 1925		BALTIMORE		JAMES H. HARRIS		JAN 15 1925		BALTIMORE	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Frederick</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Frederick</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Everett</u> Last <u>Cooper</u>			4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1900</u>	9. AGE (in years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaners</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>S. Leslie Cooper</u>		
14. MOTHER'S MAIDEN NAME <u>Bertha M. Griffin</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1922-1925</u>		
16. SOCIAL SECURITY NO. <u>217-10-9083</u>			17. INFORMANT <u>Teresa Murry Cooper</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Dr. B. O. Thomas</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>Sept 15, 1958</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		24a. REC'D BY REGISTRAR <u>Frederick-Maryland</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE <u>SEP 16 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DOI: 10.1002/for

1990-1991

(2011)

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1, Film G234, 10/10/58 icy

Reg. Dist. No. 10297

1. PLACE OF DEATH a. COUNTY 10155 Frederick Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattstown Hyattstown 15x-2	
c. LENGTH OF STAY IN lb Life		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Franklin Curtis		4. DATE OF DEATH September 27 19 58	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1938 19 yrs. Months Days Min.
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Curtis		14. MOTHER'S MAIDEN NAME Bliss Prather	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT William Curtis Hyattstown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupered liver 812x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compound fracture of left thigh and leg DUE TO (c) Compound fracture of right ankle			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apperant struck by automobile	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5 22 9/27/58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 355		20f. (City or town) (County) Hyattstown Montgomery (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 27, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/58	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

10182

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Mt. Airy		c. LENGTH OF STAY IN 1b 3 wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural-- Frederick.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodville			d. STREET ADDRESS R.D. 1 , Central		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle R. Last DUVALL			4. DATE OF DEATH Month 9- Day 19- Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1941		9. AGE (In years last birthday) 17 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm laborer		10b. KIND OF BUSINESS OR INDUSTRY general		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME LeRoy Duvall			14. MOTHER'S MAIDEN NAME Nettie E. Shaffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-38-1055		17. INFORMANT Mr. LeRoy Duvall, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 9/12/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Winter					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Farm Tractor upset			
20c. TIME OF INJURY Month, Day, Year Hour 3 a.m. 9-19 1958 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20f. (City or town) Woodville, Frederick, Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.C. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.C. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9-19-158			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1958		22c. NAME OF CEMETERY OR CREMATORY Locust Grove	
22d. LOCATION (City, town, or county) Frederick Co., Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR SEP 23 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10153

10156 Items 2,3 Film 0234 9/24/58 gaj

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Missouri b. COUNTY Indiana ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville (Douglas Co. Mo.)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fredrick Memorial Hospital		d. STREET ADDRESS Throckmorth/11/11/1961	
3. NAME OF DECEASED (Type or print) Elma First Hilton Middle Last Fike		4. DATE OF DEATH 9 Month 9 Day 1958	
5. SEX Female	6. COLOR OR RACE white	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov 15 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME J B Hilton		14. MOTHER'S MAIDEN NAME Arlene Belle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Lester & Fike	
17. INFORMANT Burkittsville		Address Burkittsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile	
20c. TIME OF INJURY Hour 7:30 a.m. 9/9 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) Burkittsville (County) Fredrick (State) Ind
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. D. Thomas M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. D. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-15-58	
22c. NAME OF CEMETERY OR CREMATORY Terra Alta WVA		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ray & Gladhill		24a. REC'D BY REGISTRAR Middleton DATE SEP 16 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10115

NAME: *James B. Miller*
 SEX: *Male*
 AGE: *70*
 DATE OF BIRTH: *Nov 12 1901*
 PLACE OF BIRTH: *St. Louis, Mo.*
 OCCUPATION: *Retired*
 CAUSE OF DEATH: *Heart Failure*
 MANNER OF DEATH: *Natural*
 SIGNATURE OF EXAMINER: *[Signature]*
 DATE: *Nov 15 1971*

1-5
 MD STATE
 HEALTH DEPT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10157

CERTIFICATE OF DEATH

Reg. Dist. No.

10154

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>		d. STREET ADDRESS. <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles F. Firor</u>		4. DATE OF DEATH <u>Sept 5</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Firor</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Lightner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Lost</u>	
17. INFORMANT <u>Mrs. Jessie S. Firor</u>		Address <u>Thurmont, Md/</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Coronary thrombosis with myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>1 day</u> <u>10 yrs +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>58</u> , to <u>9/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>58</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>9/5/58</u> ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u> <u>Frederick, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Brethern Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Md.</u>	
24a. RECEIVED BY REGISTRAR <u>SEP 10 1958</u>		DATE <u>SEP 10 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE	

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revised: 1998

82-10169-10-1 [K792v]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10158

10155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 115 East Second Street		e. STREET ADDRESS 115 East Second Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) VALLIE		First RAMSBURG		Middle FISHER		Last FISHER		4. DATE OF DEATH Month September	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 29, 1885		9. AGE (In years last birthday) 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Thomas Ramsburg		14. MOTHER'S MAIDEN NAME Margaret Claggett		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5058		17. INFORMANT Address Mr. Alden E. Fisher, Frederick R.D.#2, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 5 minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) West Third Street		(County) (State)	
21. I certify that I attended the deceased from July 1, 1958 , to Sept 16, 1958 , that I last saw the deceased alive on Sept 16, 1958 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick, Maryland		DATE SIGNED 9/17/58					
ACTUAL SIGNATURE Thomas E. Stone		M.D. West Third Street		DATE 9/17/58					
PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone		Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR 18 58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Airy R.F.D.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Ambriose Fogle		4. DATE OF DEATH September 27 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY WOOD MFG.	
11. BIRTHPLACE (State or foreign country) Frederick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel S. Fogle		14. MOTHER'S MAIDEN NAME Cecilia Marton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-28-1086	
17. INFORMANT Mrs William Fogle		Address Mt Airy R.F.D4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Contusion DUE TO 9020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hours			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off porch striking head on metal can	
20c. TIME OF INJURY Month, Day, Year 9/27 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Mt Airy R.F.D. 4 Frederick Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		DATE SIGNED September 27. 58	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/58	
22c. NAME OF CEMETERY OR CREMATORY METHODIST CEM		22d. LOCATION (City, town, or county) TAYLORSVILLE MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE D. P. Hartzler & Sons, New Windsor Md		24. REC'D BY REGISTRAR SEP 30 '58	
24b. REGISTRAR'S SIGNATURE Clayton E. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1920	
Place of Birth		Occupation		Cause of Death		Manner of Death	
New York City		Teacher		Heart Disease		Natural	
Residence at Time of Death		Usual Residence		Physician's Name		Physician's Address	
123 Main St		456 Oak St		Dr. J. Smith		101 N. Broadway	
Time of Death		Place of Death		Hospital Name		Hospital Address	
10:00 AM		Home		St. Mary's		100 N. Charles St	
Time of Burial		Place of Burial		Burial Home Name		Burial Home Address	
1:00 PM		Catholic Cemetery		St. Mary's		100 N. Charles St	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal		Official Seal	
Jan 16, 1920		Baltimore		[Seal]		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11297

10161

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Brunswick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>120 East "C" Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Alfred</u> Last <u>Fowler</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1924</u>
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brakeman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Virgil Fowler</u>		14. MOTHER'S MAIDEN NAME <u>Regie Kelley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Ruth Fowler Brunswick, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, Pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disseminated Giant Follicle Lymphoblastoma</u> DUE TO (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>56</u> , to <u>Sept. 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept. 29</u> , 19 <u>58</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas R. Reid, M.D.</u>		ADDRESS (Street, city or town, state) <u>Professional Bldg., Frederick, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas R. Reid</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		22d. LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. R. Felt</u> ADDRESS <u>Brunswick, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct 9 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10162 CERTIFICATE OF DEATH

10158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN IB 3 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovettsville 83x-3		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last RAYMOND H. FRYE		4. DATE OF DEATH Month Day Year September 3, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Oct 1898
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Butler L. Frye		14. MOTHER'S MAIDEN NAME Rosa Grubb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-14-8390	
17. INFORMANT Address Mrs. Essie Frye (Same as item #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Rupture of the myocardium DUE TO (b) Coronary thrombosis with myocardium DUE TO (c) infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5-10 min 1 wk 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/1, 1958, to 9/3, 1958, that I last saw the deceased alive on 9/3, 1958, and that death occurred at 1:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase M.D.		ADDRESS (Street, city or town, state) 4 East Church Street DATE SIGNED 9/4/58	
PHYSICIAN'S NAME (Type) Henry V. Chase, M. D.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-58	
22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 5 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

RECEIVED
MAR 10 1918
MARSHALL STATE DEPARTMENT OF HEALTH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		March 10, 1918	
Place of Birth		Cause of Death		Occupation		Residence	
New York City		Typhoid Fever		Farmer		Rural, New York	
Date of Birth		Time of Death		Place of Death		Physician	
January 1, 1883		10:00 AM		Home		Dr. J. H. Smith	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister	
J. H. Smith		A. B. Doe		C. D. Roe		E. F. Roe	
Official Seal		Official Seal		Official Seal		Official Seal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

10159

10176

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 70 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 815 N. Maple Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
f. STREET ADDRESS 815 N. Maple Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie Elizabeth Gladstone		4. DATE OF DEATH Month 9 Day -23 Year 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Shry		14. MOTHER'S MAIDEN NAME Prucilla Mc Kimmey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bessie Heffner, Brunswick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hem 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9/16/58 944			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/6 to 9/21 , 19 58 , that I last saw the deceased alive on 9/21 , 19 58 , and that death occurred at 3:45 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 9/24/58 ACTUAL SIGNATURE J.G.F. Smith M.D. PHYSICIAN'S NAME (Type) J.G.F. Smith Brunswick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-58	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Feete ADDRESS B. Lee Feete, Brunswick, Md.		24a. REC'D BY REGISTRAR SEP 29 1958 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Krause			

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• 2014

1997

*.B. McInerney, author of "Signed" and "Sue"

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

The Waste Framework Directive

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...and the ...

Self-Reported Delinquency

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROCKY RIDGE		c. LENGTH OF STAY IN 1b 8yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ROCKY RIDGE		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES CALVIN GRUBER		4. DATE OF DEATH Month Day Year SEPT 5 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 25th
9. AGE (In years last birthday) 67 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSHUA GRUBER		14. MOTHER'S MAIDEN NAME LILLY ENGLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YOS WORLD WAR I		16. SOCIAL SECURITY NO. 220-347283	
17. INFORMANT YOS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Self inflicted DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. C. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. C. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept. 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 8-1958	
22c. NAME OF CEMETERY OR CREMATORY MT HOPE		22d. LOCATION (City, town, or county) (State) WOODSBORO MD	
23. FUNERAL DIRECTOR'S SIGNATURE G. C. Barton		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 233 9-22-58 ans

10163
CERTIFICATE OF DEATH

10161

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memoria Hospital		d. STREET ADDRESS 909 Motter Place	
3. NAME OF DECEASED (Type or print) LENA Middle BURKE HAINES		4. DATE OF DEATH Month September Day 10 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Burke		14. MOTHER'S MAIDEN NAME Annie Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-5006	
17. INFORMANT Mr. Charles LeR. Haines-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1958 , to Sept 10, 1958 , that I last saw the deceased alive on Sept 10, 1958 , and that death occurred at 11 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thomas E Stone M.D. 4 W 3rd St 9-10-58 PHYSICIAN'S NAME (Type) Thomas E STONE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REG. BY REGISTRAR SEP 15 58 DATE 24b. REGISTRAR'S SIGNATURE William S. Haines	

WARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10184 CERTIFICATE OF DEATH

10162

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Middletown, Md. R # 2 COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Md.				c. LENGTH OF STAY IN 1b 412 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Victor Cullen State Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Cullen, Md.	
3. NAME OF DECEASED (Type or print) William Vincent HANCOCK				4. DATE OF DEATH Month September Day 1 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1898	
9. AGE (In years lost birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital Orderly		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Willie Hancock				14. MOTHER'S MAIDEN NAME Mary Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 577-12-2971		17. INFORMANT Address Hospital Chart, Cullen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Fever (1932) DUE TO (c) Moderately Advanced Pul. Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH One day. 26 Yrs. 8 Yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 16, 1957 , to Sept 1, 1958 , that I last saw the deceased alive on Sept. 1, 19 58 , and that death occurred at 4:50 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE T. F. Vestal				DATE SIGNED September 1, 1958			
PHYSICIAN'S NAME (Type) T. F. Vestal, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-58		22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray C. Wood				24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED MARY ANN MARY ANN</p>		<p>AGE 70 70</p>	
<p>SEX F F</p>		<p>RACE W W</p>	
<p>DATE OF DEATH 1913 1913</p>		<p>TIME OF DEATH 10:00 10:00</p>	
<p>PLACE OF DEATH HOME HOME</p>		<p>CITY BALTIMORE BALTIMORE</p>	
<p>STREET 1234 1234</p>		<p>STATE MD MD</p>	
<p>CAUSE OF DEATH 1. 2. 3. 1. 2. 3.</p>		<p>DIAGNOSIS 1. 2. 3. 1. 2. 3.</p>	
<p>DATE OF BIRTH 1843 1843</p>		<p>PLACE OF BIRTH MD MD</p>	
<p>DATE OF DEATH 1913 1913</p>		<p>TIME OF DEATH 10:00 10:00</p>	
<p>PLACE OF DEATH HOME HOME</p>		<p>CITY BALTIMORE BALTIMORE</p>	
<p>STREET 1234 1234</p>		<p>STATE MD MD</p>	
<p>CAUSE OF DEATH 1. 2. 3. 1. 2. 3.</p>		<p>DIAGNOSIS 1. 2. 3. 1. 2. 3.</p>	
<p>DATE OF BIRTH 1843 1843</p>		<p>PLACE OF BIRTH MD MD</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10163

10164

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b over 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS 210 South Market St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Augustus Middle Edward Last Heidler				4. DATE OF DEATH Month September Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. ***** WIDOWED <input checked="" type="checkbox"/> *****		8. DATE OF BIRTH Dec. 10-1869	
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Cigar Maker		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Heidler				14. MOTHER'S MAIDEN NAME Mary Heidler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-5336		17. INFORMANT Mrs. Nola Soper-210 S. Market St.-Frederick-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO (c) Arterio sclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 4 weeks app. 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 27 , 19 58 , to Sept. 24 , 19 58 , that I last saw the deceased alive on Sept. 23 , 19 58 , and that death occurred at 12:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph L. Michels				DATE SIGNED Frederick Shopping Center 9-26-58			
PHYSICIAN'S NAME (Type) Dr. Ralph L. Michels				ADDRESS Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE SEP 29 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10164

10185

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u>		c. LENGTH OF STAY IN 1b <u>life</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Homer</u> Last <u>Holter</u>				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/1931</u>		9. AGE (in years last birthday) <u>27</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Cecil K. Holter</u>				14. MOTHER'S MAIDEN NAME <u>Elsie R. Remsberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Cecil k. Holter, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Self inflicted</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/6/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company</u>				ADDRESS <u>, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10186

10165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	c. LENGTH OF STAY IN 1b Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy Route 1 Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ijamsville .. Frederick County		d. STREET ADDRESS Mt. Airy	
3. NAME OF DECEASED (Type or print) Wilbert McKinley Hoy		4. DATE OF DEATH September 27 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmers Helper		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick-Co.-Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Hoy		14. MOTHER'S MAIDEN NAME Nancy Stanton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Clifton Hoy .. 128 East St. Fred. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 10 min. to			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas Sr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas Sr.		DATE SIGNED Sept. 30, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-58	
22c. NAME OF CEMETERY OR CREMATORY Woodville		22d. LOCATION (City, town, or county) (State) Woodville Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks 111 Frederick, Md.		24a. REC'D BY REGISTRAR OCT 1 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19-08

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
RESIDENCE: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

ALL I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the person named above, and that the same is in accordance with the findings of the medical examination.

SIGNED: [illegible]
MEDICAL EXAMINER

WITNESSED: [illegible]
CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10165

CERTIFICATE OF DEATH

Reg. Dist. No.

10166

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Fred.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b MOST OF LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. STREET ADDRESS FREDERICK, MD.	
3. NAME OF DECEASED (Type or print) First HARRY Middle ROY Last KOLB		4. DATE OF DEATH Month SEPT. Day 18, Year 1958.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-81
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 8 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electrical	11. BIRTHPLACE (State or foreign country) Frederick County
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Lewis Kolb.	
14. MOTHER'S MAIDEN NAME Margaret Catherine MacGruder.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 212-03-7125		17. INFORMANT Address Mrs. Sarah Mealey, 8417, Dixon Ave. Silver Sp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 561.0 DUE TO Intussusception Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Incarcerated Hernia (c) Surgical Hernia and Adhesions following Resection of Stomach			INTERVAL BETWEEN ONSET AND DEATH 7 days. 3 yrs.? 16 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Insufficiency - renal insufficiency - bronchial pneumonia			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Sept. 17, 1958 , to Sept. 18, 1958 , that I last saw the deceased alive on Sept. 17, 1958 , and that death occurred at 4:30 A. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Frank Worthington		ADDRESS (Street, city or town, state) Frederick - Md.	
PHYSICIAN'S NAME (Type) FRANK D. WORTHINGTON, MD.		DATE SIGNED FREDERICK, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 20, 1958.	22c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY
22d. LOCATION (City, town, or county) FREDERICK, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE DAILEY'S FUNERAL HOME		24. REC'D BY REGISTRAR SEP 23 58	
24b. REGISTRAR'S SIGNATURE Arthur S. France		DATE	

CERTIFICATE OF DEATH

101165

NAME OF DECEASED FREDERICK ROBERT W. LEE		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH JAN 15 1898		PLACE OF BIRTH BIRMINGHAM, ALABAMA	
FATHER'S NAME FREDERICK ROBERT W. LEE		MOTHER'S NAME JENNIE LEE		DATE OF DEATH JAN 15 1943		PLACE OF DEATH BIRMINGHAM, ALABAMA		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
OCCUPATION ENGINEER		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE MARRIED		SINGLE		DIVORCED	
BIRTHPLACE BIRMINGHAM, ALABAMA		RESIDENCE BIRMINGHAM, ALABAMA		DATE OF BIRTH JAN 15 1898		PLACE OF BIRTH BIRMINGHAM, ALABAMA		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
FATHER'S NAME FREDERICK ROBERT W. LEE		MOTHER'S NAME JENNIE LEE		DATE OF DEATH JAN 15 1943		PLACE OF DEATH BIRMINGHAM, ALABAMA		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
OCCUPATION ENGINEER		EDUCATION HIGH SCHOOL		RELIGION METHODIST		MARRIAGE MARRIED		SINGLE		DIVORCED	
BIRTHPLACE BIRMINGHAM, ALABAMA		RESIDENCE BIRMINGHAM, ALABAMA		DATE OF BIRTH JAN 15 1898		PLACE OF BIRTH BIRMINGHAM, ALABAMA		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10167

10166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wynelle Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle M. Last KUNKLE		4. DATE OF DEATH Month September Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 1	IF UNDER 24 HRS. Hours 1 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harmon Nary		14. MOTHER'S MAIDEN NAME Clara Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Frank L. Gastley-Same as Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis DUE TO underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus 260x			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1958 to Sept 3, 1958 , that I last saw the deceased alive on Sept 3, 1958 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Stone		ADDRESS (Street, city or town, state) West Third Street, Frederick, Maryland	
DATE SIGNED 9/5/58			
PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Kutz Church Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 E. 12th St., St. Louis, Mo.		Attorney		High School		Married		4/4/68		St. Louis, Mo.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
Heart Disease		Natural		I hereby certify that the above is a true and correct statement of the facts as stated to me by the informant.							
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.		4/4/68		St. Louis, Mo.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **10168**

10167

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Guy Baxter Lynn		4. DATE OF DEATH September 10, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1867
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Worker	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Abram Lynn	
14. MOTHER'S MAIDEN NAME Mary Dorsey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Earl Lynn, Westminster, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 10, 1958 to Sept 10, 1958 that I last saw the deceased alive on Sept 10, 1958 and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. Messler		ADDRESS (Street, city or town, state) DATE SIGNED Sept 11, 58	
PHYSICIAN'S NAME (Type) John H. Messler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 13, 1958	22c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery	22d. LOCATION (City, town, or county) (State) Ladiesburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son		ADDRESS Taneytown, Md.	24a. REC'D BY REGISTRAR SEP 15 '58
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED [Faint text, possibly "John H. ..."]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1900"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "1950"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		COUNTY [Faint text, possibly "Baltimore"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. ..."]		SIGNATURE OF CORONER [Faint text, possibly "J. H. ..."]		SIGNATURE OF REGISTRAR [Faint text, possibly "J. H. ..."]		SIGNATURE OF WITNESS [Faint text, possibly "J. H. ..."]	
CERTIFICATE OF DEATH [Faint text, possibly "This is to certify that the above named person died on the ... day of ... 1950 at the age of ... years ..."]		[Faint text, possibly "J. H. ..."]		[Faint text, possibly "J. H. ..."]		[Faint text, possibly "J. H. ..."]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10168

CERTIFICATE OF DEATH

Reg. Dist. No.

10169

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 1 mo			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK Memorial				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle LEE Last MAIN Jr.				4. DATE OF DEATH Month Sept Day 10 Year 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Aug '58	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) MARYland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert L. MAIN Sn			
14. MOTHER'S MAIDEN NAME Charlotte J. ENGLE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Mr. Robert L. Main, Sr.—Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocarditis, acute 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA, PROB. VIRAL DUE TO (c) 18 hrs. 18 hrs							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 9 Sept , 19 58 , to 10 Sept , 19 58 , that I last saw the deceased alive on 10 Sept , 19 58 , and that death occurred at 8 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Guest				ADDRESS (Street, city or town, state) 7 E. Church St. DATE SIGNED 10 Sept 58			
PHYSICIAN'S NAME (Type) Dr. R. L. Guest				FREDERICK Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR SEP 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10187
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick Co. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Md. c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Cumberland, Rt. # 2 d. STREET ADDRESS Wms. Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Archie D. NIXON First Middle Last		4. DATE OF DEATH Sept. 27 Month Day Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 - 25 - 1898 9. AGE (In years lost birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Cement & Sup. Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elwood Nixon		14. MOTHER'S MAIDEN NAME Estella Twigg.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-05-7055	
17. INFORMANT Hospital Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis, Far Advanced 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of Liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-18 , 19 58 , to 9-27 , 19 58 , that I last saw the deceased alive on 9 - 27 , 19 58 , and that death occurred at 7:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED T. F. Vestal, M. D. 9-27-58			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type) T. F. Vestal, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 30, 1958	
22c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Right		24a. REC'D BY REGISTRAR SEP 30 '58	
ADDRESS Cumb. Md. 311 Decatur St.		24b. REGISTRAR'S SIGNATURE Charles E. Huns	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10188
CERTIFICATE OF DEATH

10171

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonesboro</u> c. LENGTH OF STAY IN 1b <u>4 weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeders Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sabillasville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>May</u> Last <u>Overcash</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1958</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 7, 1889</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Myersville Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Baker</u>				14. MOTHER'S MAIDEN NAME <u>Florence Bowser</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Glenn L. Overcash, Sabillasville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Generalized arteriosclerosis</u> DUE TO (b) <u>Cerebral paralysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug 15</u> , 19 <u>58</u> , to <u>Sept 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>G. W. Lellan</u> M.D. <u>Boonesboro</u>						ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/4/58</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Lellan</u>						<u>md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin Pa</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Grove</u> <u>Waynesboro, Pa.</u>						24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10169

CERTIFICATE OF DEATH

Reg. Dist. No.

10172

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle B Last Pittinger		4. DATE OF DEATH Month Sept. Day 22 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR: Months 90 Days 22 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Pittinger		14. MOTHER'S MAIDEN NAME Anna Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James. G. Pittinger		Address Philadlephia, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.0 (b) Arteriosclerotic Heart Disease and DUE TO Chronic Nephrosclerosis (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Neck rt Femur 1 mo. ago			
INTERVAL BETWEEN ONSET AND DEATH 3 wks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell at home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22, 19 58 , to Sept. 22, 19 58 , that I last saw the deceased alive on Sept. 22, 19 58 , and that death occurred at 6:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frank Damazo M.D. 7 W. 3rd st Frederick, Md DATE SIGNED 9/22/58			
ACTUAL SIGNATURE Frank Damazo M.D.			
PHYSICIAN'S NAME (Type) Frank Damazo M.D. 7 W. 3rd st Frederick, Md			
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 9-25-58	
22c. NAME OF CEMETERY OR CREMATORY Graceham Moravian Cem		22d. LOCATION (City, town, or county) (State) Graceham, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
24a. REC'D BY REGISTRAR SEP 26 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10189

CERTIFICATE OF DEATH

Reg. Dist. No.

10173

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen, Maryland				c. LENGTH OF STAY IN 1b 392 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills, Maryland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital			
d. STREET ADDRESS none				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Malcolm E. Pyles				4. DATE OF DEATH Month Day Year September 22, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 23, 1908	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Franklin W. Pyles				14. MOTHER'S MAIDEN NAME Roberta (unknown last name)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-05-9493		17. INFORMANT Address Records of Victor Cullen State Hosp.; Cullen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis, Active DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema DUE TO (c) Cardiac Failure							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 26, 1957 , to Sept. 22, 1958 , that I last saw the deceased alive on Sept. 21, 1958 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE T.F. Vestal				ADDRESS (Street, city or town, state) Victor Cullen State Hospital			
PHYSICIAN'S NAME (Type) T.F. Vestal, M.D.; Superintendent				Cullen, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-25-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. ...				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

MARILAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10170 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10174

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USA Medical Unit, Ft Detrick, Md.		d. STREET ADDRESS 40 East 3rd St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Melvin Last Shipley, Sr.		4. DATE OF DEATH Month Sept. Day 3 Year 1958	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 28 May 1897
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR: Months 3 Days 5 Hours 8 Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Franklin Shipley		14. MOTHER'S MAIDEN NAME Fanny Easterday	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-10-5460	
17. INFORMANT Harry M. Shipley, Jr.,		Address 6001 Charlotte St. Springfield, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, severe, generalized DUE TO (c) 3 years INTERVAL BETWEEN ONSET AND DEATH Immediately			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Pulmonary Embolic			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 June , 19 58 , to 3 Sep. , 19 58 , that I last saw the deceased alive on 3 Sep. , 19 58 , and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Richard B. Hornick M.D. USA Medical Unit, Ft. Detrick, Md.-3 Sep 58			
PHYSICIAN'S NAME (Type) RICHARD B. HORNICK, Captain, MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 6, 1958	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR [REDACTED]</p>	
<p>13. DATE OF DEATH [REDACTED]</p>		<p>14. PLACE OF DEATH [REDACTED]</p>	
<p>15. TIME OF DEATH [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED [REDACTED]</p>		<p>18. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>19. SIGNATURE OF BURIAL SOCIETY [REDACTED]</p>		<p>20. SIGNATURE OF FUNERAL HOME [REDACTED]</p>	
<p>21. SIGNATURE OF CHURCH [REDACTED]</p>		<p>22. SIGNATURE OF CEMETERY [REDACTED]</p>	
<p>23. SIGNATURE OF MINISTRY [REDACTED]</p>		<p>24. SIGNATURE OF CLERGY [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED [REDACTED]</p>		<p>26. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>27. SIGNATURE OF BURIAL SOCIETY [REDACTED]</p>		<p>28. SIGNATURE OF FUNERAL HOME [REDACTED]</p>	
<p>29. SIGNATURE OF CHURCH [REDACTED]</p>		<p>30. SIGNATURE OF CEMETERY [REDACTED]</p>	
<p>31. SIGNATURE OF MINISTRY [REDACTED]</p>		<p>32. SIGNATURE OF CLERGY [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10171

Item 9 Film G233 9-11-58 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick 35 d. STREET ADDRESS 9 North 10th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First B Middle Spurrer Last 4. DATE OF DEATH Sep 4 1958		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 26-1884 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR: Months 4 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.Co 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John H. Spurrer 14. MOTHER'S MAIDEN NAME Laura Beall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. World 1 17. INFORMANT Edward H. Spurrer Address Brunswick, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebral Ischemia, severe DUE TO 3 days (c) Hypertensive Cardiovascular Disease 6 yrs + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9/2 , 19 58 , to 9/4 , 19 58 , that I last saw the deceased alive on 9/3 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 9/4/58 ACTUAL SIGNATURE Henry V. Chase M.D. PHYSICIAN'S NAME (Type) Henry V. Chase Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9-6-1958 22c. NAME OF CEMETERY OR CREMATORY Marvin Chapel 22d. LOCATION (City, town, or county) (State) Plain #4 Maryland		23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fester ADDRESS Brunswick, Maryland 24a. REC'D BY REGISTRAR SEP 8 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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Environ Biol Fish (2015) 98:1195–1206

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Lawrence, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10172

CERTIFICATE OF DEATH

Reg. Dist. No.

10176

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. STREET ADDRESS Jefferson Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Armatage Middle S. Last Stern				4. DATE OF DEATH Month September Day 20 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1905		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Registered Nurse		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence M. Snider				14. MOTHER'S MAIDEN NAME Bessie Neal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-24-3002		17. INFORMANT Address Mr. Arthur Stern (Husband) Braddock Heights, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lower nephron nephrosis DUE TO (c) Acute fatty liver INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 1 1/2 months?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/28 , 19 58 , to 9/20 , 19 58 , that I last saw the deceased alive on 9/20 , 19 58 , and that death occurred at 1:50 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 728 N. Market St. Frederick, Md. DATE SIGNED 10/2							
ACTUAL SIGNATURE L. R. Schoolman				PHYSICIAN'S NAME (Type) L. R. Schoolman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 23, '58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Schickel ADDRESS 1201 N. Market St. Fred				24a. REC'D BY REGISTRAR DATE SEP 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1917

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15, 1917		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Myocardial Infarction		9. PERIOD OF ILLNESS 2 weeks	
10. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		11. SIGNATURE OF WITNESSES John Doe, Jr., Mary Doe		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF BIRTH Jan 1, 1872		15. OCCUPATION Teacher	
16. MARITAL STATUS Married		17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESSES None		20. PREVIOUS SURGERIES None		21. PREVIOUS TRAUMAS None	
22. PREVIOUS DRUGS None		23. PREVIOUS ACCIDENTS None		24. PREVIOUS TOXIC ACTIONS None	
25. PREVIOUS INFECTIOUS DISEASES None		26. PREVIOUS CONSUMPTION None		27. PREVIOUS TUBERCULOSIS None	
28. PREVIOUS SYPHILIS None		29. PREVIOUS GONORRHOEA None		30. PREVIOUS SYPHILITIC LESIONS None	
31. PREVIOUS SYPHILITIC LESIONS None		32. PREVIOUS SYPHILITIC LESIONS None		33. PREVIOUS SYPHILITIC LESIONS None	
34. PREVIOUS SYPHILITIC LESIONS None		35. PREVIOUS SYPHILITIC LESIONS None		36. PREVIOUS SYPHILITIC LESIONS None	
37. PREVIOUS SYPHILITIC LESIONS None		38. PREVIOUS SYPHILITIC LESIONS None		39. PREVIOUS SYPHILITIC LESIONS None	
40. PREVIOUS SYPHILITIC LESIONS None		41. PREVIOUS SYPHILITIC LESIONS None		42. PREVIOUS SYPHILITIC LESIONS None	
43. PREVIOUS SYPHILITIC LESIONS None		44. PREVIOUS SYPHILITIC LESIONS None		45. PREVIOUS SYPHILITIC LESIONS None	
46. PREVIOUS SYPHILITIC LESIONS None		47. PREVIOUS SYPHILITIC LESIONS None		48. PREVIOUS SYPHILITIC LESIONS None	
49. PREVIOUS SYPHILITIC LESIONS None		50. PREVIOUS SYPHILITIC LESIONS None		51. PREVIOUS SYPHILITIC LESIONS None	
52. PREVIOUS SYPHILITIC LESIONS None		53. PREVIOUS SYPHILITIC LESIONS None		54. PREVIOUS SYPHILITIC LESIONS None	
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58. PREVIOUS SYPHILITIC LESIONS None		59. PREVIOUS SYPHILITIC LESIONS None		60. PREVIOUS SYPHILITIC LESIONS None	
61. PREVIOUS SYPHILITIC LESIONS None		62. PREVIOUS SYPHILITIC LESIONS None		63. PREVIOUS SYPHILITIC LESIONS None	
64. PREVIOUS SYPHILITIC LESIONS None		65. PREVIOUS SYPHILITIC LESIONS None		66. PREVIOUS SYPHILITIC LESIONS None	
67. PREVIOUS SYPHILITIC LESIONS None		68. PREVIOUS SYPHILITIC LESIONS None		69. PREVIOUS SYPHILITIC LESIONS None	
70. PREVIOUS SYPHILITIC LESIONS None		71. PREVIOUS SYPHILITIC LESIONS None		72. PREVIOUS SYPHILITIC LESIONS None	
73. PREVIOUS SYPHILITIC LESIONS None		74. PREVIOUS SYPHILITIC LESIONS None		75. PREVIOUS SYPHILITIC LESIONS None	
76. PREVIOUS SYPHILITIC LESIONS None		77. PREVIOUS SYPHILITIC LESIONS None		78. PREVIOUS SYPHILITIC LESIONS None	
79. PREVIOUS SYPHILITIC LESIONS None		80. PREVIOUS SYPHILITIC LESIONS None		81. PREVIOUS SYPHILITIC LESIONS None	
82. PREVIOUS SYPHILITIC LESIONS None		83. PREVIOUS SYPHILITIC LESIONS None		84. PREVIOUS SYPHILITIC LESIONS None	
85. PREVIOUS SYPHILITIC LESIONS None		86. PREVIOUS SYPHILITIC LESIONS None		87. PREVIOUS SYPHILITIC LESIONS None	
88. PREVIOUS SYPHILITIC LESIONS None		89. PREVIOUS SYPHILITIC LESIONS None		90. PREVIOUS SYPHILITIC LESIONS None	
91. PREVIOUS SYPHILITIC LESIONS None		92. PREVIOUS SYPHILITIC LESIONS None		93. PREVIOUS SYPHILITIC LESIONS None	
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97. PREVIOUS SYPHILITIC LESIONS None		98. PREVIOUS SYPHILITIC LESIONS None		99. PREVIOUS SYPHILITIC LESIONS None	
100. PREVIOUS SYPHILITIC LESIONS None		101. PREVIOUS SYPHILITIC LESIONS None		102. PREVIOUS SYPHILITIC LESIONS None	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10173

10177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Butler		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Butler 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital			d. STREET ADDRESS 222 American Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lula Beatrice Stone			4. DATE OF DEATH Month September Day 29 Year 19 58		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1905		9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Daniel Stone			14. MOTHER'S MAIDEN NAME Martha Diggs		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 205-12-4688		17. INFORMANT Leslie Stone Address 167 W. All Saint St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac infarct new & old 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. B.O. Thomas, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 29, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9-29-58		22c. NAME OF CEMETERY OR CREMATORY Butler — Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III		ADDRESS Frederick, Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
				24b. REGISTRAR'S SIGNATURE <i>Charles E. Hicks</i>	

FOR STATE
HEALTH DEPT.

PLACE OF DEATH

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10190

CERTIFICATE OF DEATH

10178

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JOHNSVILLE</u>				d. STREET ADDRESS <u>JOHNSVILLE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT STUART STULLER</u>				4. DATE OF DEATH Month Day Year <u>SEPT 3 1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 5-1889</u>	9. AGE (In years last birthday) yrs. <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BY DAY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>SAMUEL STULLER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH KEMPER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-5165</u>		17. INFORMANT Address <u>BEUKAH STULLER UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/19, 1958</u> to <u>9/3, 1958</u> , that I last saw the deceased alive on <u>9/3, 1958</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>9/4/58</u>			
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>				<u>NEW WINDSOR MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM. UNIONTOWN</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hartzler Sons Union Bridge Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. T. H. & H. H. H.</u>			

MAR. LAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10179

Reg. Dist. No.

10191

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN lb 20 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Murvil Middle L. Last Toms		4. DATE OF DEATH Month Sept. Day 26 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1910
9. AGE (in years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machine operator		10b. KIND OF BUSINESS OR INDUSTRY road construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Martin Luther Toms		14. MOTHER'S MAIDEN NAME Estie V. Reeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-10-4481	
17. INFORMANT Mrs. Edna Toms		Address Middletown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Self inflicted DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Sept. 26, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/28/1958	22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	22d. LOCATION (City, town, or county) (State) Boonsboro Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 24 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10134

1817

THE CITY OF

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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10174

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 South Market Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Joseph Last Tyeryar				4. DATE OF DEATH Month Sept. Day 9 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED *** DIVORCED ***	8. DATE OF BIRTH Dec. 12-1889		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Retail Plumbing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frederick F. Tyeryar				14. MOTHER'S MAIDEN NAME Mary Tuman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-2740		17. INFORMANT Franklin J. Tyeryar-11 W. South St.-Frederick-			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardio-vascular disease with probable acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-15-1956 to 9-9-1958 , that I last saw the deceased alive on 9-9-1958 , and that death occurred at 12 Noon , from the causes and on the date stated above.							
ACTUAL SIGNATURE Rex R. Martin M.D.				ADDRESS (Street, city or town, state) 35 E. Church Street		DATE SIGNED 9-11-58	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin				Frederick-Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 12-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick- Maryland		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
				24b. REGISTRAR'S SIGNATURE Quilley & House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE PAY DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF MINISTER SIGNATURE OF CLERGYMAN SIGNATURE OF CHURCH SIGNATURE OF FUNERAL HOME SIGNATURE OF BURIAL PLACE SIGNATURE OF INTERMENT PLACE SIGNATURE OF CEMETERY SIGNATURE OF BURIAL PLACE SIGNATURE OF INTERMENT PLACE SIGNATURE OF CEMETERY		DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE PAY DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF MINISTER SIGNATURE OF CLERGYMAN SIGNATURE OF CHURCH SIGNATURE OF FUNERAL HOME SIGNATURE OF BURIAL PLACE SIGNATURE OF INTERMENT PLACE SIGNATURE OF CEMETERY SIGNATURE OF BURIAL PLACE SIGNATURE OF INTERMENT PLACE SIGNATURE OF CEMETERY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10177

CERTIFICATE OF DEATH

Reg. Dist. No. 10181

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. LENGTH OF STAY IN 1b 35			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 East Potomac St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hannah Mary Walter				4. DATE OF DEATH Month Day Year 9 17 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-29-1875	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk				10b. KIND OF BUSINESS OR INDUSTRY Merchandise		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Robert Walter				14. MOTHER'S MAIDEN NAME Reberta Brannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Mrs. Ida L. Willey, Brunswick, Maryland			
17. INFORMANT Address Mrs. Ida L. Willey, Brunswick, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5 , 19 58 , to Sept. 17 , 19 58 , that I last saw the deceased alive on Sept. 17 , 19 58 , and that death occurred at 8:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 So. Maryland Ave. Brunswick, Md. DATE SIGNED 9-18-58 ACTUAL SIGNATURE C. T. Byron Kao M.D. PHYSICIAN'S NAME (Type) C. T. Byron Kao, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Middletown, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. L. Foster Brunswick, Maryland				24a. REC'D BY REGISTRAR SEP 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shookstown		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shookstown Frederick R.F.D. 7	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Frederick R.F.D. 7		
3. NAME OF DECEASED (Type or print) First Middle Last Jerome Domnick Wickless			4. DATE OF DEATH Month Day Year September 21 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1882	9. AGE (in years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Frederick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Wickless			14. MOTHER'S MAIDEN NAME Laura Joy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Cora Wickless, Frederick R.F.D. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 21, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/58	22c. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cem.	22d. LOCATION (City, town, or county) (State) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey		ADDRESS 1201 N. Market st. Frederick, Md.		24a. REC'D BY REGISTRAR SEP 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPARTMENT OF HEALTH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
New York City		Teacher		Heart Disease	
Date of Death		Place of Death		Time of Death	
Jan 1, 1912		Home		10:00 AM	
Physician		Medical Examiner		Signature	
Dr. J. Smith		Dr. J. Smith		[Signature]	
Hospital		Burial Place		Remarks	
St. Mary's		Catholic Cemetery		No autopsy performed	
Funeral Home		Interment		Disposition of Body	
Brown & Sons		Catholic Cemetery		Buried	
Burial Date		Burial Time		Remarks	
Jan 3, 1912		10:00 AM		No autopsy performed	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10193

CERTIFICATE OF DEATH

Reg. Dist. No.

10183

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville-Rural RD#1		c. LENGTH OF STAY IN 1b 4 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosemont		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle JANE Last WILES		4. DATE OF DEATH Month September Day 8 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Aug 1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Mullican		14. MOTHER'S MAIDEN NAME Victoria Lare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William C. Wiles		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/6 , 19 58 , to 9/7 , 19 58 , that I last saw the deceased alive on 9/7 , 19 58 , and that death occurred at 9/7 , 19 58 , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 9-8-58			
ACTUAL SIGNATURE _____ M.D.		PHYSICIAN'S NAME (Type) J. G. F. Smith, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-58	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE SEP 10 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

